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|--|--|--------------|----------------------|------------------|--|
| MEDICATION VISIT (face to face) | | DATE: | BILLING TIME: | LOCATION: | |
| Target Symptoms/Response to Meds: | | | | | |
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| Evaluation of Side Effects/Action Taken: <input type="checkbox"/> N/A <input type="checkbox"/> T.D. Absent <input type="checkbox"/> T.D. present (specify): | | | | | |
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| | | | | | |
| Client Compliance to Medication Plan: | | | | | |
| Lab Check: <input type="checkbox"/> N/A Findings: | | | | | |
| Interventions: <input type="checkbox"/> see Outpt. Medication Record | | | | | |
| | | | | | |
| Follow-Up: RTC: | | | | | |
| Recovery Update: | | | | | |
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| Additional Actions Taken and Comments: | | | | | |
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| OTHER MEDICATION SUPPORT SERVICES (in person or by phone) | | DATE: | BILLING TIME: | LOCATION: | |
| (Giving advice re: meds; collateral information to family, caretaker, etc.) Document information discussed and specify person contacted.) | | | | | |
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| Signature: | | | Printed Name: | | |
| MEDICATION VISIT INTERDISCIPLINARY NOTE Confidential Patient Information See W&I Code 5328 | | | NAME: | | |
| | | | CHART NO: | | |
| | | | DOB: | | |
| | | | PROGRAM: | | |